

## Regional Support Team Referral Form

### Community Resource Consultant

Region:	Date of request:	Individual's unique ID:
Submitted by:	Agency:	Phone:
<b>Notification and Choice</b>		
Notification form completed and on file?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Types of residential options discussed (check all that apply):	<input type="checkbox"/> Own Home <input type="checkbox"/> Leased Apartment <input type="checkbox"/> Family Home <input type="checkbox"/> Sponsored Home <input type="checkbox"/> Group Home (4 or fewer) <input type="checkbox"/> Group Home (5 or more) <input type="checkbox"/> ICF <input type="checkbox"/> Nursing Home <input type="checkbox"/> Training Center <input type="checkbox"/> Other: _____	
Individual/family selected residential option:		
Types of employment/day options discussed (check all that apply):	<input type="checkbox"/> Self Employment <input type="checkbox"/> Individual Supported Employment <input type="checkbox"/> Group Supported Employment <input type="checkbox"/> Career Training/Education <input type="checkbox"/> Prevocational Services <input type="checkbox"/> Day Support <input type="checkbox"/> Volunteer <input type="checkbox"/> Retirement <input type="checkbox"/> Other: _____	
Individual/family selected day services option:		
Chance to talk with other individuals with ID/DD who live and work successfully in the community or with their family members provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
List any desired options that are unavailable:		
Describe any additional information provided by the individual/family regarding this referral:		
<b>Referral reason (check only one)      Issues and actions taken (as applicable):</b>		
<input type="checkbox"/>	a. Difficulty finding services and supports in the community within 3 months of receiving a slot.	a. Describe gaps/barriers and what has been tried and learned?
<input type="checkbox"/>	b. Recommended to move to a group home of five or more individuals.	b. Describe the reason(s) for selecting setting and whether the choice of less restrictive settings have been offered:
<input type="checkbox"/>	c. Recommended to move into a nursing home or ICF.	c. Describe the reason(s) for selecting and whether the choice of less restrictive settings have been offered:
<input type="checkbox"/>	d. Pattern of repeatedly being removed from home.	d. Describe the reason(s) for being removed from home and what has been tried:

<input type="checkbox"/>	e. Other reason	e. Describe assistance needed/barriers, reason for referral or additional comments:					
<b>Living Situation and Supports</b>							
<b>Current living situation:</b>	<input type="checkbox"/> Own home <input type="checkbox"/> With family <input type="checkbox"/> Sponsored home <input type="checkbox"/> Group home (4 or fewer) <input type="checkbox"/> Group home (5 or greater) <input type="checkbox"/> ICF <input type="checkbox"/> Nursing facility <input type="checkbox"/> Other:						
<b>Describe the individual's good life</b>							
<b>Supports</b>	Receiving	Planned	Needed		Receiving	Planned	Needed
Waiver:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specialized Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment/Day services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experience with Autism Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing (RN/LPN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Supports (PBS/ABA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Modifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Consult other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric/MH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CRC recommendations:</b>							
<b>RST referral needed?</b> <input type="checkbox"/> yes <input type="checkbox"/> no; <b>If yes, date of RST meeting:</b>							
<b>RST Recommendations:</b>							
#	Action	Responsible Person			Complete by date		
<b>Resolution</b>							
Provided by: _____ Date: _____							